

## 12901 CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH: Tylerton, Md. (Crisfield)		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Somerset	MARYLAND	STATE Tylerton, Md.	COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Crisfield	LENGTH OF STAY (in this place) all life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Crisfield, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) Newell James Bradshaw		4. DATE OF DEATH: Dec. 29 1956	
5. SEX: M	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH: Feb. 7, 1903
9. AGE last birthday: 53 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:		10b. KIND OF BUSINESS OR INDUSTRY: Waterman	
11. BIRTHPLACE (State or foreign country): Tylerton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: John Lewis Bradshaw		14. MOTHER'S MAIDEN NAME: Olevia Marshall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: 194-10-9431	
17. INFORMANT & ADDRESS: Mrs. Audrey Bradshaw, wife		Tylerton, Md.	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
193x Immediate cause		(a) melanotic cancer of the brain	
Antecedent cause(s)		(b) DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		(c) DUE TO	
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. none			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 28, 1956, to Dec. 28, 1956, that I last saw the deceased alive on Dec. 28, 1956, and that death occurred at Dec. 29, 1956 from the causes and on the date stated above.			
SIGNATURE Barbara Hueston M.D.		DATE SIGNED Jan. 3, 1957	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 1/1/57	
NAME OF CEMETERY OR CREMATORY Tylerton		LOCATION (City, town, or county) Tylerton, Md.	
DATE REC'D BY LOCAL REGISTRAR 1/8/57		REGISTRAR'S SIGNATURE Barbara L. Adams	
24. FUNERAL DIRECTOR		ADDRESS	
Barbara L. Adams		Bradshaw & Sons, Crisfield, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 14 1957  
BUREAU V. S.

STATE OF NEW YORK  
CERTIFICATE OF DEATH

NAME OF DECEASED: [REDACTED]  
AGE: [REDACTED]  
SEX: [REDACTED]  
RACE: [REDACTED]  
DATE OF BIRTH: [REDACTED]  
PLACE OF BIRTH: [REDACTED]  
EDUCATION: [REDACTED]  
OCCUPATION: [REDACTED]  
MARRIAGE: [REDACTED]  
RELIGION: [REDACTED]  
CAUSE OF DEATH: [REDACTED]  
MANNER OF DEATH: [REDACTED]  
DATE OF DEATH: [REDACTED]  
PLACE OF DEATH: [REDACTED]  
SIGNATURE OF DECEASED: [REDACTED]  
SIGNATURE OF WITNESSES: [REDACTED]  
SIGNATURE OF PHYSICIAN: [REDACTED]  
SIGNATURE OF CORONER: [REDACTED]  
SIGNATURE OF JUDGE: [REDACTED]  
SIGNATURE OF CLERK: [REDACTED]

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

12902

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>				c. LENGTH OF STAY IN 1b <b>11 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCready Hospital</b>				d. STREET ADDRESS <b>X1 Marion Station</b>			
3. NAME OF DECEASED (Type or print) First <b>PEARL</b> Middle <b>MISSOURI</b> Last <b>BUTLER</b>				4. DATE OF DEATH Month <b>December</b> Day <b>22</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 30, 1900</b>		9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Accomack County, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Oliver Satchell</b>				14. MOTHER'S MAIDEN NAME <b>Missouri Frances Mears</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>203-0903599</b>		17. INFORMANT Address <b>Herschel Butler--Marion Station, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxic Myocarditis</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Inanition</b> (c) <b>Carcinoma of Cervix &amp; Metastases</b>						INTERVAL BETWEEN ONSET AND DEATH <b>On mo.</b> <b>Five mo.</b> <b>Five years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Feb 13</b> , 19 <b>53</b> , to <b>Dec 22</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Dec 22</b> , 19 <b>56</b> , and that death occurred at <b>12:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. N. Barr</b>				M.D. <b>Crisfield, Md.</b>		DATE SIGNED <b>1/2/57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. A. N. Barr</b>				ADDRESS <b>Main St.--Crisfield, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 24, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Marion Station, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>1/8/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>Barbara S. Adams</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12903

CERTIFICATE OF DEATH

12886

Reg. Dist. No. 265

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCready Hospital</b>				d. STREET ADDRESS <b>S. Somerset Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>ELMER</b> Last <b>BYRD</b>				4. DATE OF DEATH Month <b>December</b> Day <b>10</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 30, 1889</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Groceryman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Grocery</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Napoleon B. Byrd</b>				14. MOTHER'S MAIDEN NAME <b>Sarah C. Harrison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address <b>Melvin Byrd—Crisfield, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis -</b> <b>332x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hemiplegia -</b> DUE TO (c) <b>10 months.</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Mar 13, 19 50</b> to <b>Dec 10, 19 56</b> , that I last saw the deceased alive on <b>Dec 10, 19 56</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Main St.--Crisfield, Md.</b> DATE SIGNED <b>12/12/56</b>							
ACTUAL SIGNATURE <b>C. G. Rawley</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. C. G. Rawley</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 12, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>12/14/56</b>		24b. REGISTRAR'S SIGNATURE <b>Barbara S. Redman</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

12887

261

12904

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marumscosom, Co.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Fitchett</u> Last <u>Fitchett</u>		4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1865</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Marumscosom, Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Leah Tilghman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Margaret Waters</u> Address <u>1613 N. 3rd St. Chester, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis - C. aut. Nephritis</u> DUE TO (c) <u>General Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>at autopsy, 1957</u> , to <u>12-25-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-25-</u> , 19 <u>56</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George C. Coulbourn</u> M.D.		ADDRESS (Street, city or town, state) <u>Marion Sta. Md.</u> DATE SIGNED <u>12-27-56</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE C. COULBOURN MD.</u>		<u>MARION STA., MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/28/56</u>	
22c. NAME OF CEMETERY OR REPOSITORY <u>Ebenezer</u>		22d. LOCATION (City, town, or county) (State) <u>Marumscosom, Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Ward</u> ADDRESS <u>Marion Sta., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>12-27-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Nellie D. Payne</u>			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, place, and cause of death. The text is mostly illegible due to blurring and bleed-through from the reverse side.

BUREAU V. S.

DEC 28 1956

RECEIVED



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12889  
 Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <span style="float:right">12889</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> c. LENGTH OF STAY IN lb <b>Lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pear St.</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> d. STREET ADDRESS <b>Pear St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>OSBORNE</b> Last <b>HILL</b>				4. DATE OF DEATH Month <b>December</b> Day <b>28</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 1, 1926</b>	
9. AGE (In years last birthday) <b>30</b> yrs.		IF UNDER 1 YEAR Months <b>30</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Fish Market</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Edward L. Hill</b>				14. MOTHER'S MAIDEN NAME <b>Beatrice Evans</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>Korean War</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Edward L. Hill--Crisfield, Maryland</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Burned to Death--3rd Degree Burns-- Part</b> <span style="float:right">Upper</span> DUE TO <b>First degree burns of entire body &amp; face</b> <span style="float:right">Instant</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Suffocation</b> DUE TO <b>Suffocation</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Subject was sleeping when house caught afire</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>2:15</b> p. m. <b>Dec. 28</b> 19 <b>56</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Crisfield</b> (County) <b>Somerset</b> (State) <b>Md.</b>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>William H. Coulbourn, M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. William H. Coulbourn</b>				ASSISTANT MEDICAL EXAMINER <b>FOR SOMERSET COUNTY, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Dec. 29, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>1/1/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>Barbara L. Adams</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Edward J. Hill		Male		30		November 1, 1928		Chicago, Ill.		Chicago, Ill.		Heart disease		Natural	
Occupation		Education		Marital Status		Date of Marriage		Date of Death		Time of Death		Place of Death		Physician's Name	
Laborer		High School		Married		1945		November 1, 1957		11:00 AM		Chicago, Ill.		Dr. J. J. Hill	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Funeral Home		Signature of Cemetery	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU W. 3

14N 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG208 12-26-56 et.

12890  
Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>L.</b> Last <b>Howard</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>12</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1878</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Somerset Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Grayson Jones</b>		14. MOTHER'S MAIDEN NAME <b>Matilda Furnace</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO.	
17. INFORMATION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary heart disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.H. Johnson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.H. Johnson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Dec 14-1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 16, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Polks Road</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Vernon, Som. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Ward</b>		ADDRESS <b>Marion St., Md.</b>	
24a. REC'D BY REGISTRAR <b>12/14/56</b>		24b. REGISTRAR'S SIGNATURE <b>R.H. Johnson, M.D.</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12891

Reg. Dist. No. 360

12906

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Princess Anne</u>	c. LENGTH OF STAY IN 1b <u>5 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Princess Anne</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Ray</u> Middle <u>Johnson</u> Last		4. DATE OF DEATH Month <u>Dec</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/8/1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph H. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Mc Gue</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war and dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Johnson - Rt. 2 - Pr. Anne, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dead when I saw him.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R.H. Johnson</u>		DATE SIGNED <u>December 26 - 56</u>	
EXAMINER'S NAME (Type) <u>R.H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12/27/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>	22d. LOCATION (City, town, or county) (State) <u>Princess Anne Route 2 Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Sumner</u>		24a. REC'D BY REGISTRAR <u>12/26/56</u> 24b. REGISTRAR'S SIGNATURE <u>R.H. Johnson, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		PATHOLOGICAL FINDINGS		LABORATORY FINDINGS	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **12892**

**12907**

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chesfield</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chesfield</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Nancy</u> Last <u>Lawson</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 29 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Bernard Lawson</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Lawson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mr Hce Crockett Chesfield Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Vagina</u> <u>176x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept.</u> , 19 <u>56</u> , to <u>Dec. 28</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Dec 27</u> , 19 <u>56</u> , and that death occurred at <u>3:41 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah M. Peyton</u> M.D. <u>Chesfield, Md</u>		DATE SIGNED <u>12/29/56</u>	
PHYSICIAN'S NAME (Type) <u>Sarah M. Peyton</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Dec 30 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Eschery Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Chesfield Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Lennon Chesfield Md</u>		24. REC'D BY REGISTRAR <u>Barbara L. Adorn</u>	
ADDRESS		DATE <u>1/1/57</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH	
11. DATE OF DEATH		12. TIME OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERK		19. SIGNATURE OF JUDGE		20. SIGNATURE OF SHERIFF	
21. SIGNATURE OF CHURCH		22. SIGNATURE OF FUNERAL HOME		23. SIGNATURE OF BURIAL		24. SIGNATURE OF CREMATION		25. SIGNATURE OF OTHER	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12899

## CERTIFICATE OF DEATH

Reg. Dist. No. 365

12893

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>15 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>714 W. Main St.</b>		d. STREET ADDRESS <b>714 W. Main St.</b>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>EDWARD</b> Last <b>PARKINSON, SR.</b>		4. DATE OF DEATH Month <b>December</b> Day <b>3</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1, 1895</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	
11. BIRTHPLACE (State or foreign country) <b>Deal Island, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Thomas Parkinson</b>		14. MOTHER'S MAIDEN NAME <b>Emma Abbott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-12-2338</b>	
17. INFORMANT <b>Mrs. Eva Hall--Crisfield, Md.</b>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>199.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Metastasis</b> DUE TO (c) <b>Carcinoma, Epidermoid Rt Bronchus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 weeks</b> <b>7 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 25</b> , 19 <b>56</b> , to <b>Dec 3</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Dec 2</b> , 19 <b>56</b> , and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b> DATE SIGNED <b>12/3/56</b>			
ACTUAL SIGNATURE <b>A. N. Barr</b> M.D.		DATE SIGNED <b>12/3/56</b>	
PHYSICIAN'S NAME (Type) <b>Dr. A. N. Barr</b>		Main St.--Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 5, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		ADDRESS _____	
24a. REC'D BY REGISTRAR DATE <b>12/6/56</b>		24b. REGISTRAR'S SIGNATURE <b>Barbara S. Adams</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED John Thomas Johnson		SEX Male		AGE 45		DATE OF DEATH Dec. 1, 1956	
PLACE OF DEATH Johns Hopkins Hospital		CITY Baltimore		STATE Maryland		COUNTY Baltimore	
OCCUPATION Physician		EDUCATION College		RELIGION Catholic		MARRIAGE Married	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		CERTIFICATE NO. 123-456789		REGISTERED Yes	
SIGNATURE OF PHYSICIAN John T. Johnson		SIGNATURE OF WITNESSES John T. Johnson		SIGNATURE OF DECEASED John T. Johnson		SIGNATURE OF FUNERAL HOME John T. Johnson	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12894

12908

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCready Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CEPHRONIA</b> Middle <b>ESTHER</b> Last <b>POWELL</b>		4. DATE OF DEATH Month <b>December</b> Day <b>23</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 8, 1877</b>
9. AGE (In years last birthday) <b>79</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William H. H. Bailey</b>		14. MOTHER'S MAIDEN NAME <b>Alice Robinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Chester Powell—Marion Station, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia, Acute Dil of heart - 422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Chronic Myocarditis - General Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>904.9</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall - Crushed + multiple fracture of right hip (femur)</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 7, 1956</b> , to <b>Dec. 23, 1956</b> , that I last saw the deceased alive on <b>Dec. 23, 1956</b> , and that death occurred at <b>12:28 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George C. Coulbourn</b>		ADDRESS (Street, city or town, state) <b>Marion Station, Md.</b>	
DATE SIGNED <b>12-26-56</b>			
PHYSICIAN'S NAME (Type) <b>Dr. George C. Coulbourn</b>		<b>Marion Station, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 25, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Marion Station, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>12/26/56</b>		24b. REGISTRAR'S SIGNATURE <b>Nellie D. Payne</b>	

CERTIFICATE OF DEATH

Reg. No. 10

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Alice V. Robinson		Female		35		Oct. 8, 1887		Maryland		Baltimore, Maryland		Heart Disease		Oct. 28, 1956		10:00 AM		St. Paul & Northern		George O. Robinson		John J. Robinson	
Relationship to Deceased		Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Manner of Death		Burial or Disposition		Funeral Home		Burial Place		Date of Burial		Signature of Minister	
Wife		Housewife		High School		Married		None		None		Natural		Buried		Robinson & Sons - Baltimore, Md.		St. Paul & Northern		Oct. 28, 1956		None	

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DEC 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12895

12909

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCready Hospital</b>				d. STREET ADDRESS <b>Calvary Section</b>			
3. NAME OF DECEASED (Type or print) First <b>HANNAH</b> Middle <b>FLUEHART</b> Last <b>STEVENS</b>				4. DATE OF DEATH Month <b>December</b> Day <b>24</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1898</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Tennysen Fluehart</b>				14. MOTHER'S MAIDEN NAME <b>Hattie Wharton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Albert E. Whitman-Crisfield, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lympho-sarcoma</b> <b>200.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>9 mo.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 3, 1956</b> , to <b>Dec. 24, 1956</b> , that I last saw the deceased alive on <b>Dec 24, 1956</b> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b> DATE SIGNED <b>12/29/56</b> ACTUAL SIGNATURE <b>C. G. Rawley</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. C. G. Rawley</b> Main St.--Crisfield, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 26, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Crisfield Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>12/28/56</b>		24b. REGISTRAR'S SIGNATURE <b>Barbara L. Adams</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12896

12910

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Since Birth</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCready Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	
4. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>BIRL</b> Last <b>TAWES</b>		4. DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 4, 1956</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years lost birthday) yrs. <b>0</b> Months <b>0</b> Days <b>2</b> Min.
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Elwath W. H. Tawes</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Olsson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Elwath W.H.Tawes-Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776x Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>Nov 4, 1956</b> , to <b>Nov 4, 1956</b> , that I last saw the deceased alive on <b>Nov 4, 1956</b> , and that death occurred at <b>8 P M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>C. G. Rawley</b> M.D. <b>12/5/56</b> PHYSICIAN'S NAME (Type) <b>Dr. C. G. Rawley</b> <b>Main St.--Crisfield, Md.</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>Dec. 5, 1956</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Crisfield Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b> ADDRESS 24a. REC'D BY REGISTRAR DATE <b>12/6/56</b> 24b. REGISTRAR'S SIGNATURE <b>Barbara S. Adore</b>			

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12911

## CERTIFICATE OF DEATH

13116

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. Lawsonia</b>		e. STREET ADDRESS <b>R.F.D. Lawsonia</b>	
3. NAME OF DECEASED (Type or print) First <b>ADDIE</b> Middle <b>MAE</b> Last <b>TYLER</b>		4. DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1884</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Lawson</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Daugherty</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>William H. Tyler—R.F.D.—Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Large Colon</b> <b>153X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x Wholesome nutrition</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August, 1956, to Dec 24, 1956</b> , that I last saw the deceased alive on <b>Dec 22, 1956</b> , and that death occurred at <b>5:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Main St.--Crisfield, Md.</b> DATE SIGNED <b>12/31/56</b>			
ACTUAL SIGNATURE <b>Sarah M. Peyton</b>		M.D. <b>334 Main St - Crisfield, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Sarah M. Peyton</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 31, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>1/8/57</b>		24b. REGISTRAR'S SIGNATURE <b>Barbara S. Adams</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12912  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 9 Film G209 1-21-57 et  
CERTIFICATE OF DEATH

12897

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCreedy Memorial Hospital</b>				d. STREET ADDRESS <b>46 Maryland Ave.</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>WASHINGTON</b> Last <b>TYLER</b>				4. DATE OF DEATH Month <b>December</b> Day <b>12</b> Year <b>19 56</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 14, 1890</b>			
9. AGE (In years last birthday) <b>66 65</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min.		IF UNDER 24 HRS. Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Producer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>									
13. FATHER'S NAME <b>Charles C. Tyler</b>				14. MOTHER'S MAIDEN NAME <b>Addie Bozman</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Agnes J. Tyler-46 Maryland Ave.-Crisfield</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> <b>Uremia</b> DUE TO <b>Chronic Nephritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiac Disease</b> (c) <b>Hypertensive Cardiac Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 yr</b> <b>8 yrs</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. <b>11</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <b>Dec 5</b> , 19 <b>56</b> to <b>Dec 12</b> , 19 <b>56</b> that I last saw the deceased alive on <b>Dec 12</b> , 19 <b>56</b> , and that death occurred at <b>1 P. M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D.				ADDRESS (Street, city or town, state) <b>Main St.--Crisfield, Md.</b>					
DATE SIGNED <b>12/12/56</b>									
PHYSICIAN'S NAME (Type) <b>Dr. Sarah M. Peyton</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 14, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>12/28/56</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Barbara S. Adams</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		Male		45		October 14, 1890		Wilmington		Delaware		Delaware		United States of America	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
1400 Maryland Ave.		Physician		Myocardial Infarction		Several days		McGovern Hospital		Wilmington		Delaware		United States of America	
DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATIONS		URINE		FECES	
October 14, 1930		10:30 AM		100.0		60		120/80		20		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL DIRECTOR		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CHURCH CLERK		SIGNATURE OF OTHER	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. S.

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RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12898

Reg. Dist. No. 265

12900

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>				d. STREET ADDRESS <u>Calvary Section</u>			
3. NAME OF DECEASED (Type or print) <u>MINNIE</u> First Middle Last				4. DATE OF DEATH <u>DEC 1</u> Month Day Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-22-1890</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Household duties</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WILLIAM WARD</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA CULLEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Meyer Lee Ward</u> Address <u>Crisfield md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Hemiplegia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Anteroseptal Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 mo.</u> <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 ch. pneumonia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Dec. 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 30</u> , 19 <u>56</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sarah M. Peyton</u>				ADDRESS (Street, city or town, state) <u>334 Main St. Crisfield</u> DATE SIGNED <u>12/1/56</u>			
PHYSICIAN'S NAME (Type) <u>Sarah M. Peyton</u>				<u>Crisfield, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-3-56</u>		<u>Sunnyridge</u>		<u>Hopewell md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Switzer</u> ADDRESS <u>Crisfield</u>				24a. REC'D BY REGISTRAR <u>12/4/56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Beatrice L. Adams</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 31

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13115

12913

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wenona</b>		c. LENGTH OF STAY IN life <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wenona</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>at home</b>				d. STREET ADDRESS <b>1/2 mile off main road</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>James White</b>				4. DATE OF DEATH Month Day Year <b>December 23, 1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 2, 1887</b>	
9. AGE (In years last birthday) <b>69 yrs.</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>21</b>		IF UNDER 24 HRS. Hours <b>21</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seafood</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>oystering-crabbing</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alexander White</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Elizabeth White - Wenona, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Heart Disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>5</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R. H. Johnson</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R. H. Johnson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Dec 26-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/26/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>		22d. LOCATION (City, town, or county) (State) <b>Wenona, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Webster Deaf Island</b>				24a. REC'D BY REGISTRAR DATE <b>12/27/56</b>		24b. REGISTRAR'S SIGNATURE <b>Lola J. Wheatley</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF RECORDS		23. SIGNATURE OF VITALS		24. SIGNATURE OF DEATH	
25. SIGNATURE OF BIRTH		26. SIGNATURE OF MARRIAGE		27. SIGNATURE OF DIVORCE	
28. SIGNATURE OF WEDDING		29. SIGNATURE OF ANNUAL		30. SIGNATURE OF DEATH	
31. SIGNATURE OF BURIAL		32. SIGNATURE OF CEMETERY		33. SIGNATURE OF INTERMENT	
34. SIGNATURE OF RECORDS		35. SIGNATURE OF VITALS		36. SIGNATURE OF DEATH	
37. SIGNATURE OF BIRTH		38. SIGNATURE OF MARRIAGE		39. SIGNATURE OF DIVORCE	
40. SIGNATURE OF WEDDING		41. SIGNATURE OF ANNUAL		42. SIGNATURE OF DEATH	
43. SIGNATURE OF BURIAL		44. SIGNATURE OF CEMETERY		45. SIGNATURE OF INTERMENT	
46. SIGNATURE OF RECORDS		47. SIGNATURE OF VITALS		48. SIGNATURE OF DEATH	
49. SIGNATURE OF BIRTH		50. SIGNATURE OF MARRIAGE		51. SIGNATURE OF DIVORCE	
52. SIGNATURE OF WEDDING		53. SIGNATURE OF ANNUAL		54. SIGNATURE OF DEATH	
55. SIGNATURE OF BURIAL		56. SIGNATURE OF CEMETERY		57. SIGNATURE OF INTERMENT	
58. SIGNATURE OF RECORDS		59. SIGNATURE OF VITALS		60. SIGNATURE OF DEATH	
61. SIGNATURE OF BIRTH		62. SIGNATURE OF MARRIAGE		63. SIGNATURE OF DIVORCE	
64. SIGNATURE OF WEDDING		65. SIGNATURE OF ANNUAL		66. SIGNATURE OF DEATH	
67. SIGNATURE OF BURIAL		68. SIGNATURE OF CEMETERY		69. SIGNATURE OF INTERMENT	
70. SIGNATURE OF RECORDS		71. SIGNATURE OF VITALS		72. SIGNATURE OF DEATH	
73. SIGNATURE OF BIRTH		74. SIGNATURE OF MARRIAGE		75. SIGNATURE OF DIVORCE	
76. SIGNATURE OF WEDDING		77. SIGNATURE OF ANNUAL		78. SIGNATURE OF DEATH	
79. SIGNATURE OF BURIAL		80. SIGNATURE OF CEMETERY		81. SIGNATURE OF INTERMENT	
82. SIGNATURE OF RECORDS		83. SIGNATURE OF VITALS		84. SIGNATURE OF DEATH	
85. SIGNATURE OF BIRTH		86. SIGNATURE OF MARRIAGE		87. SIGNATURE OF DIVORCE	
88. SIGNATURE OF WEDDING		89. SIGNATURE OF ANNUAL		90. SIGNATURE OF DEATH	
91. SIGNATURE OF BURIAL		92. SIGNATURE OF CEMETERY		93. SIGNATURE OF INTERMENT	
94. SIGNATURE OF RECORDS		95. SIGNATURE OF VITALS		96. SIGNATURE OF DEATH	
97. SIGNATURE OF BIRTH		98. SIGNATURE OF MARRIAGE		99. SIGNATURE OF DIVORCE	
100. SIGNATURE OF WEDDING		101. SIGNATURE OF ANNUAL		102. SIGNATURE OF DEATH	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12899  
Reg. Dist. No. 260

12974

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> <div style="text-align: right;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>VENTON</b>		c. LENGTH OF STAY IN 1b <b>3 MONTH</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>LAWRENCE</b> First Middle Last <b>WHITE</b>				4. DATE OF DEATH Month Day Year <b>12/12/56</b> <b>19</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/7/56</b>	
9. AGE (In years last birthday) yrs. Months Days <b>3</b> <b>3</b> <b>3</b>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND SOMERSET COUNTY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>	
13. FATHER'S NAME <b>ARCHIE J DOANE</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE M. WHITE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>ANNIE M. WHITE</b> Address <b>VENTON MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.H. Johnson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.H. Johnson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Dec 12-1956</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/12/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GRACE</b>		22d. LOCATION (City, town, or county) (State) <b>VENTON MARYLAND.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William A. James</b>				24a. REC'D BY REGISTRAR <b>12/14/56</b>		24b. REGISTRAR'S SIGNATURE <b>R.S. Johnson, M.D.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12915

## CERTIFICATE OF DEATH

12900

Reg. Dist. No. 360

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmount</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmount</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNETTA</b> Middle <b>REVELLE</b> Last <b>WHITEHEAD</b>		4. DATE OF DEATH Month <b>December</b> Day <b>22</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1873</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR: Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min. <b>83</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Fairmount, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John H. Revelle</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Jane Ford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>R. Bain Revelle—Fairmount, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Sclerosis</b> 422.1 DUE TO <b>10 yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility</b> DUE TO <b>10 yrs.</b> (c) <b>Arteriosclerosis</b> DUE TO <b>10 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Moderate Hypertension + Pulmonary Congestion</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August, 1955</b> to <b>Dec. 21, 1956</b> , that I last saw the deceased alive on <b>Dec. 21, 1956</b> , and that death occurred at <b>4:17 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. A. C. Lewis</b>		M.D. <b>Main St., Princess Anne Md</b> DATE SIGNED <b>12/24/56</b>	
PHYSICIAN'S NAME (Type) <b>Dr. A. C. Lewis</b>		Main St.—Princess Anne, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 24, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fairmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fairmount, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>12/57</b>		24b. REGISTRAR'S SIGNATURE <b>R. S. Johnson, M.D.</b>	

CERTIFICATE OF DEATH

300

<p>NAME OF DECEASED <b>John E. Reville</b></p>		<p>DATE OF DEATH <b>July 28, 1957</b></p>	
<p>PLACE OF DEATH <b>Home</b></p>		<p>CITY <b>St. Paul</b></p>	
<p>COUNTY <b>St. Paul</b></p>		<p>STATE <b>Minnesota</b></p>	
<p>AGE <b>63</b></p>		<p>SEX <b>Male</b></p>	
<p>DATE OF BIRTH <b>July 28, 1894</b></p>		<p>PLACE OF BIRTH <b>St. Paul</b></p>	
<p>CAUSE OF DEATH <b>Heart Disease</b></p>		<p>IMMEDIATE CAUSE <b>Myocardial Infarction</b></p>	
<p>INTERVIEWED BY <b>Dr. J. E. Reville</b></p>		<p>DATE OF INTERVIEW <b>July 28, 1957</b></p>	
<p>SIGNATURE OF DECEASED <b>John E. Reville</b></p>		<p>SIGNATURE OF WITNESS <b>Dr. J. E. Reville</b></p>	
<p>DATE OF SIGNATURE <b>July 28, 1957</b></p>		<p>DATE OF SIGNATURE <b>July 28, 1957</b></p>	

BUREAU V. R.

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1/1/57 K. J. [illegible]